HMO Value & Quality Roadmap for Wisconsin Medicaid

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August 8, 2017

Agenda

A. Background

B. Quality Roadmap

C. 2018 SSI Managed Care Proposal

D. Potentially Preventable Readmissions (PPR)

E. Alternative Payment Methods (APMs)

F. 2015 HMO Report Card

G. Conclusion

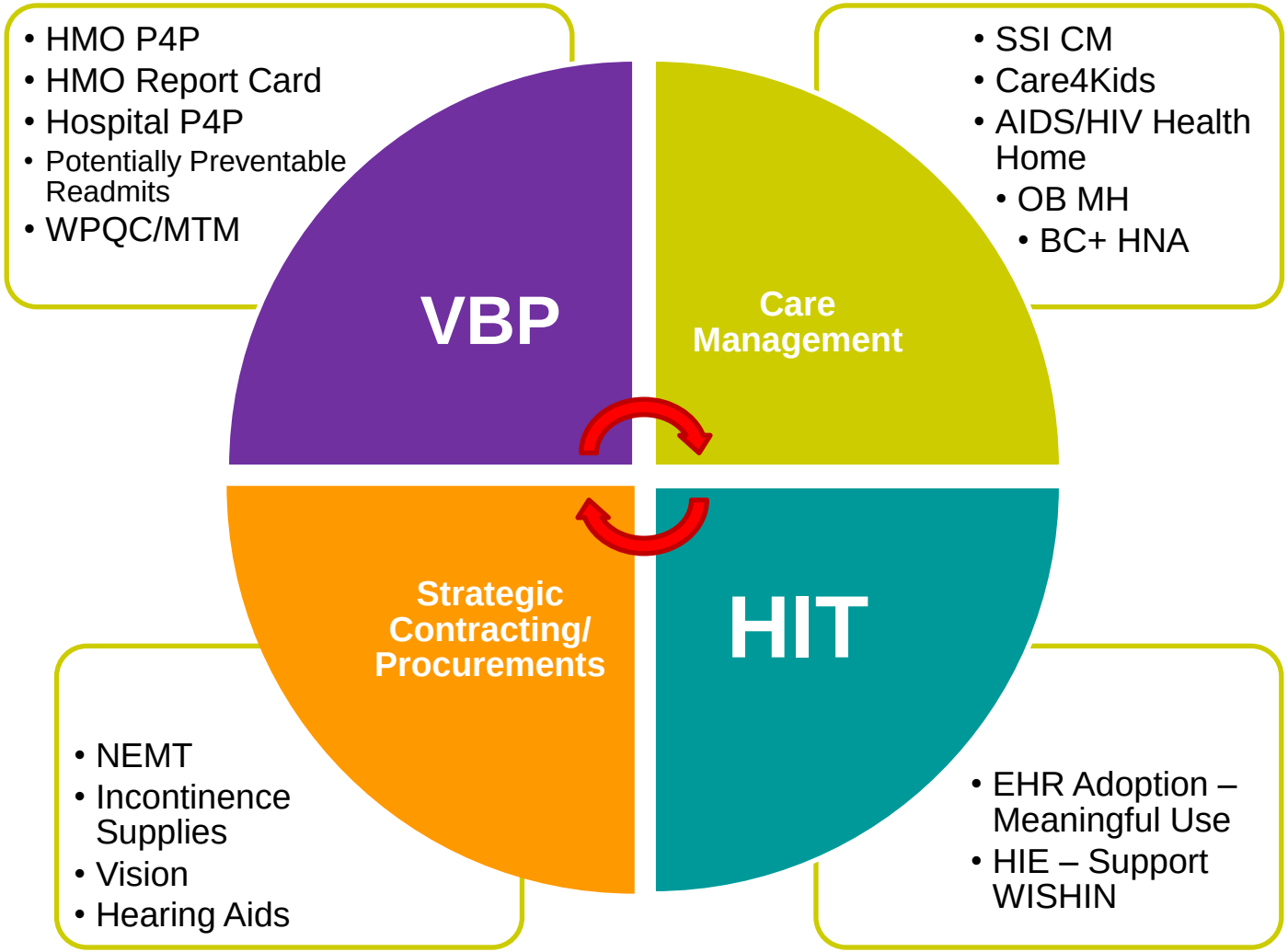
Wisconsin Managed Care Growth

- Consistent with national trends, WI Medicaid has increased enrollment in managed care, especially in last 10 years.

	March 2006	March 2017
Total MC Members	396,000	744,000
# BC+ HMOs	13	18
# SSI HMOs	5	10

- With increasing member, provider, and advocate familiarity of managed care, it has spread to more rural areas and increased number of participants.
- With effective contracting, performance monitoring, and quality initiatives, DHS has moved towards managed care for most populations historically served all or partially in fee-for-service (e.g. HIV/AIDS Health Home, Care4Kids) to help control costs and improve quality.

Quality Initiatives in WI Medicaid

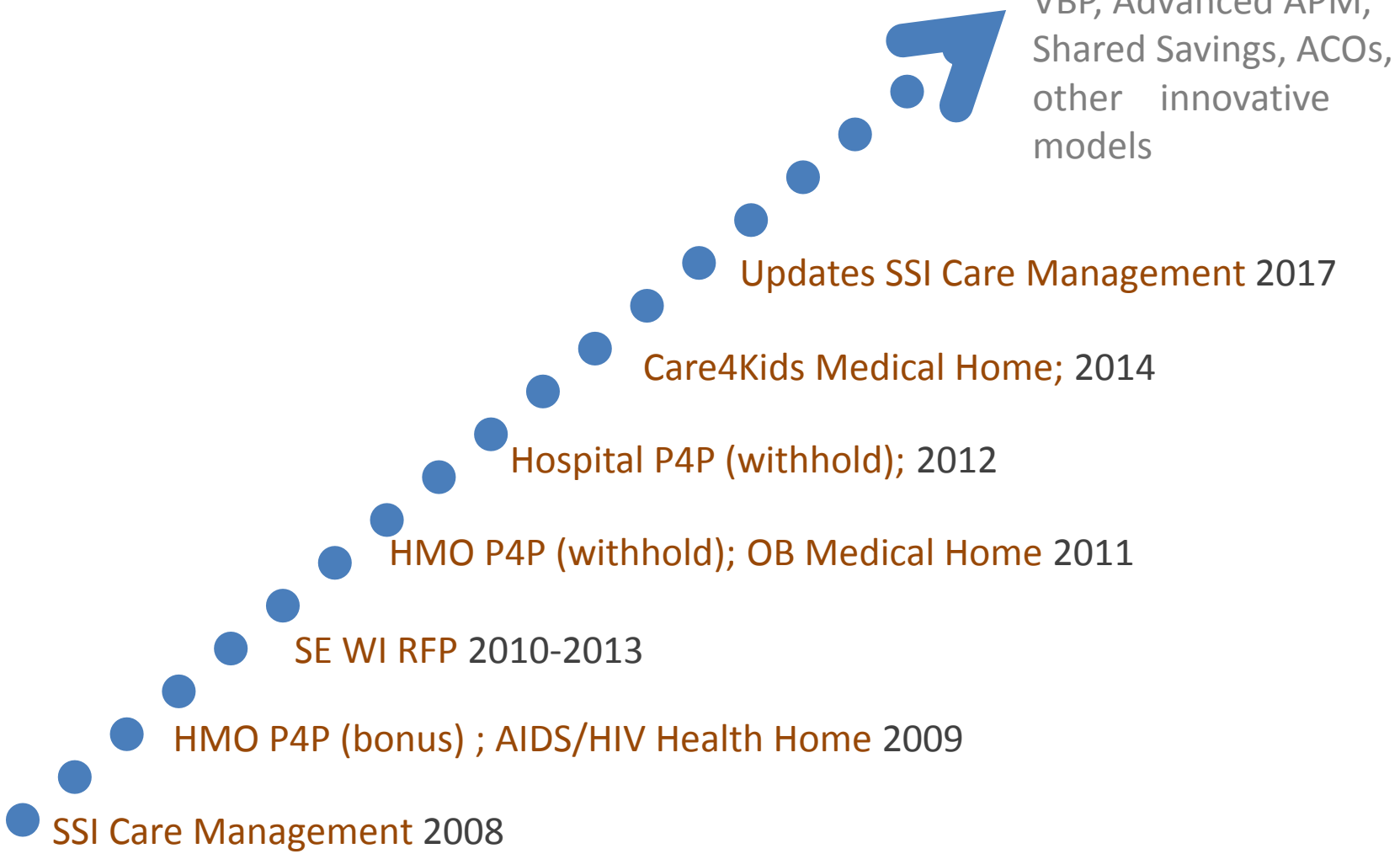


Wisconsin Medicaid Quality Objectives

Wisconsin Medicaid has the following objectives to improve quality of care:

1. Support value based purchasing
2. Minimize waste in current health care delivery for Wisconsin Medicaid members
3. Provide better care for members and better health outcomes at lower health care costs
4. Improve process and clinical performance
5. Reduce healthcare disparities

WI Medicaid HMO Quality Journey



What is Value-Based Purchasing?

- A business strategy to maximize the benefit received when buying a good or service.
- Holding **providers or contracted health entities** accountable for both the **cost and quality** of health care provided to individuals.
  - Value-Based Purchasing (VBP)
  - Value = Quality of Care / Cost of Care
- **Alternative Payment Models (APMs)** explicitly reward health care **providers** with higher and better payment methods based on **"value"** of the provider's performance relative to cost, quality, access, and/or service utilization objectives.

Medicaid Payment Reform

2015 National Association of Medicaid Directors Survey of VBP initiatives in state Medicaid programs show significant payment reform happening within many states.

Additional Payment in Support of Delivery System Reform

12

Currently Implemented

We expect many more states to have implemented this model but did not report it in our survey

Episode-Based Payment

3

Currently Implemented

4 more states are in the process of or considering implementation

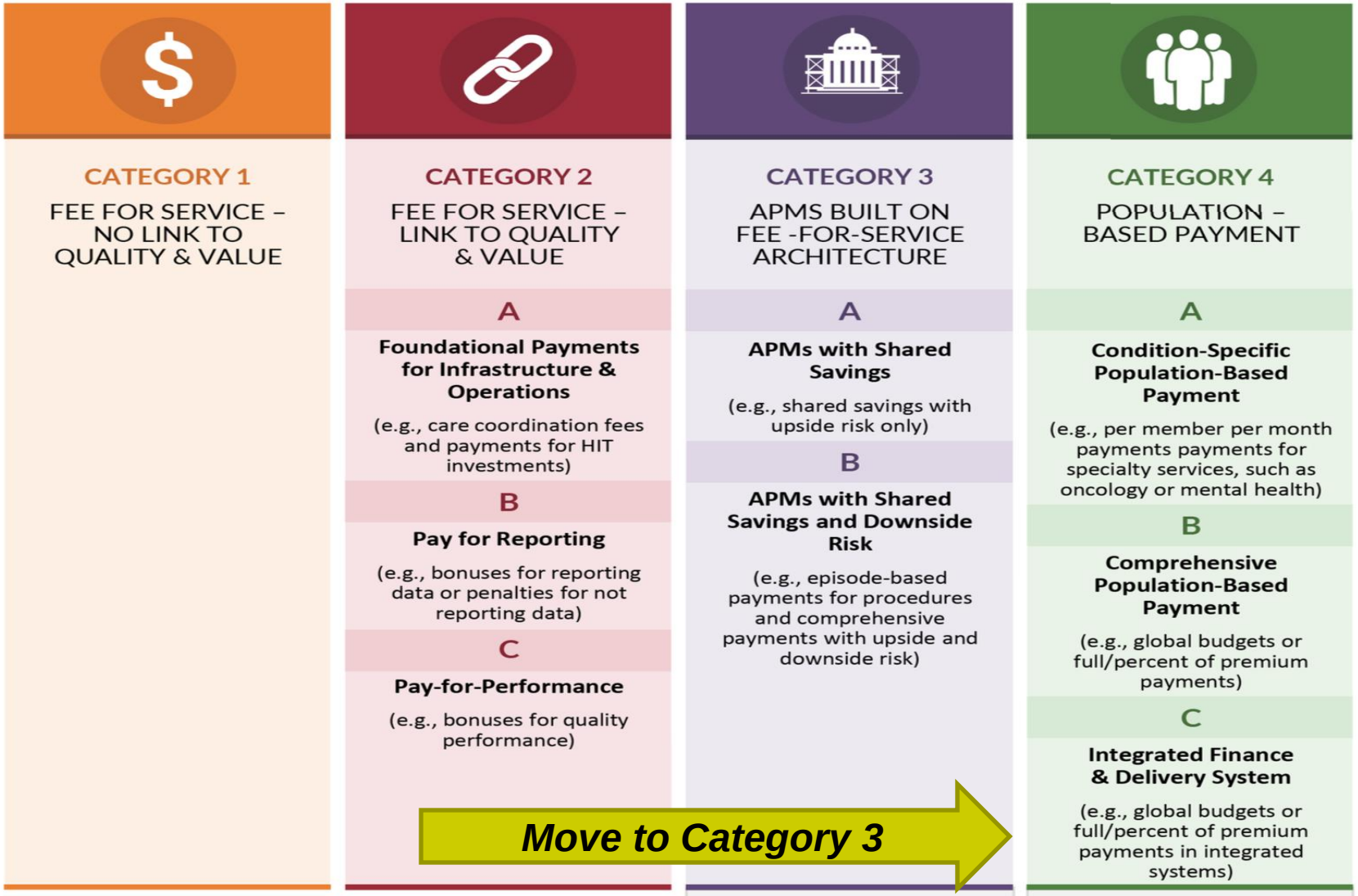
Population-Based Payment

9

Currently Implemented

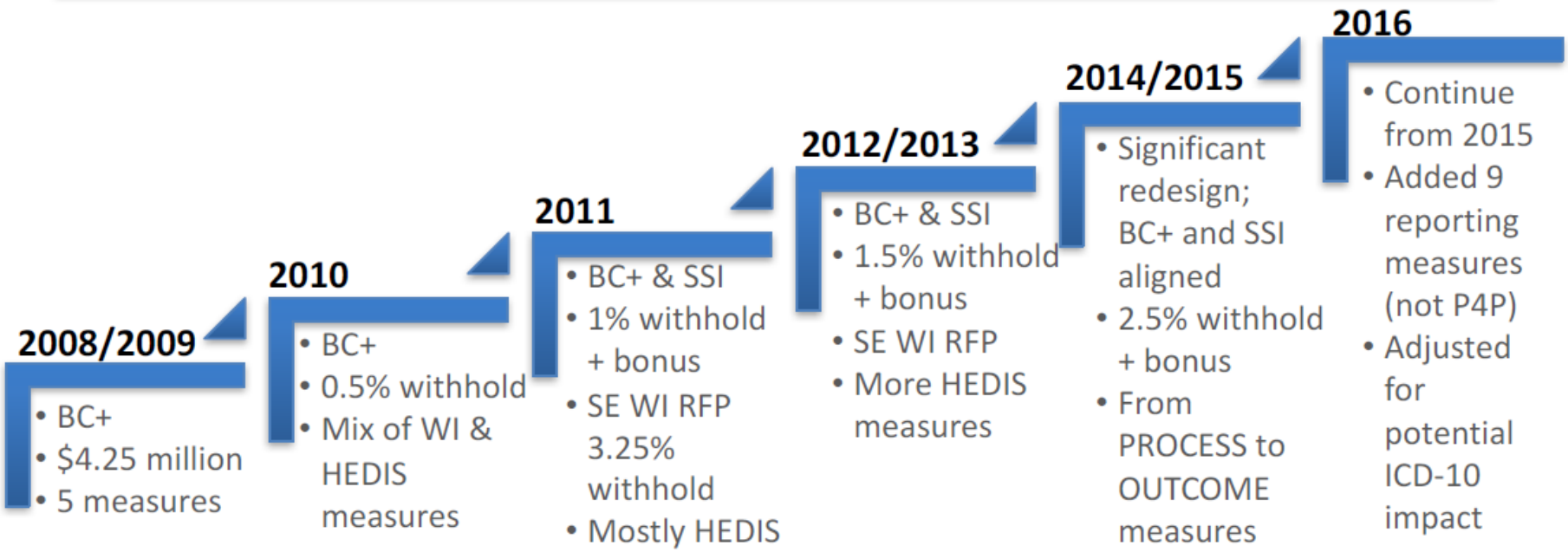
2 states are making significant changes or expanding their population-based payment model

APM Framework



Source: Health Care Payment Learning & Action Network (LAN)

HMO P4P Evolution



Summary:

- Moved towards national measures and targets
- Moved from add-on incentive to shared-risk
- Moved from process to outcome measures
- Enhanced rigor in methodology
- Adjusted for external changes (e.g., ICD-10)
- Engaged HMOs in P4P design

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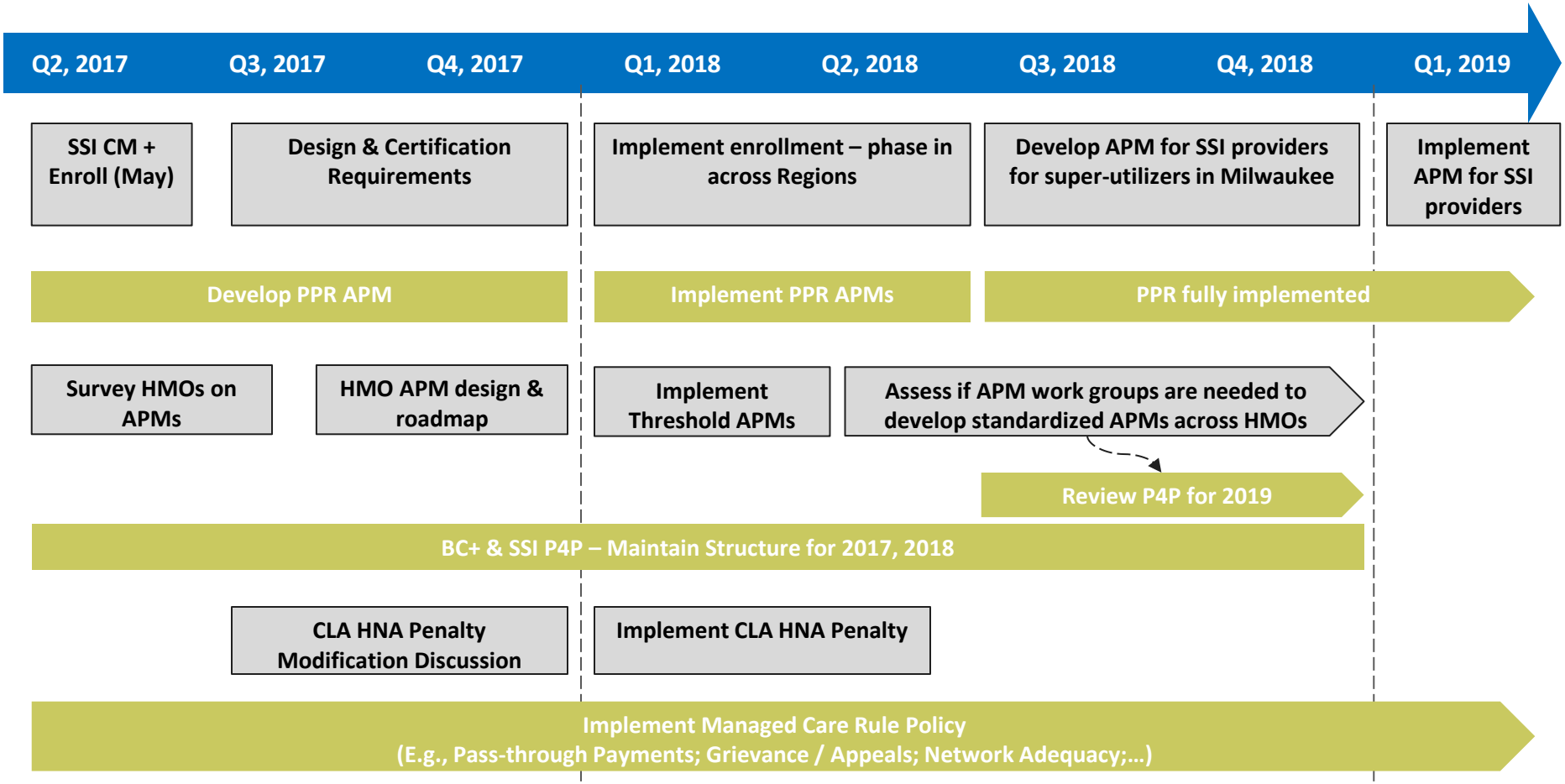
HMO Quality Roadmap



CM = Care Management
PPR = Potentially Preventable Readmissions
APM = Alternative Payment Methods
HNA = Health Needs Assessment

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SSI Managed Care Background

- Over the past several years the Department has been exploring how to best transform its delivery system to address medically complex and high cost members through the Complex Care Management (CCM) initiative. The Department's goals include:
  - Improving overall quality of life for medically complex and high cost members;
  - Establishing a new model of care delivery that incorporates high-touch, high-intensity interventions; and
  - Developing a reimbursement structure that will ultimately lead to lower costs over time.

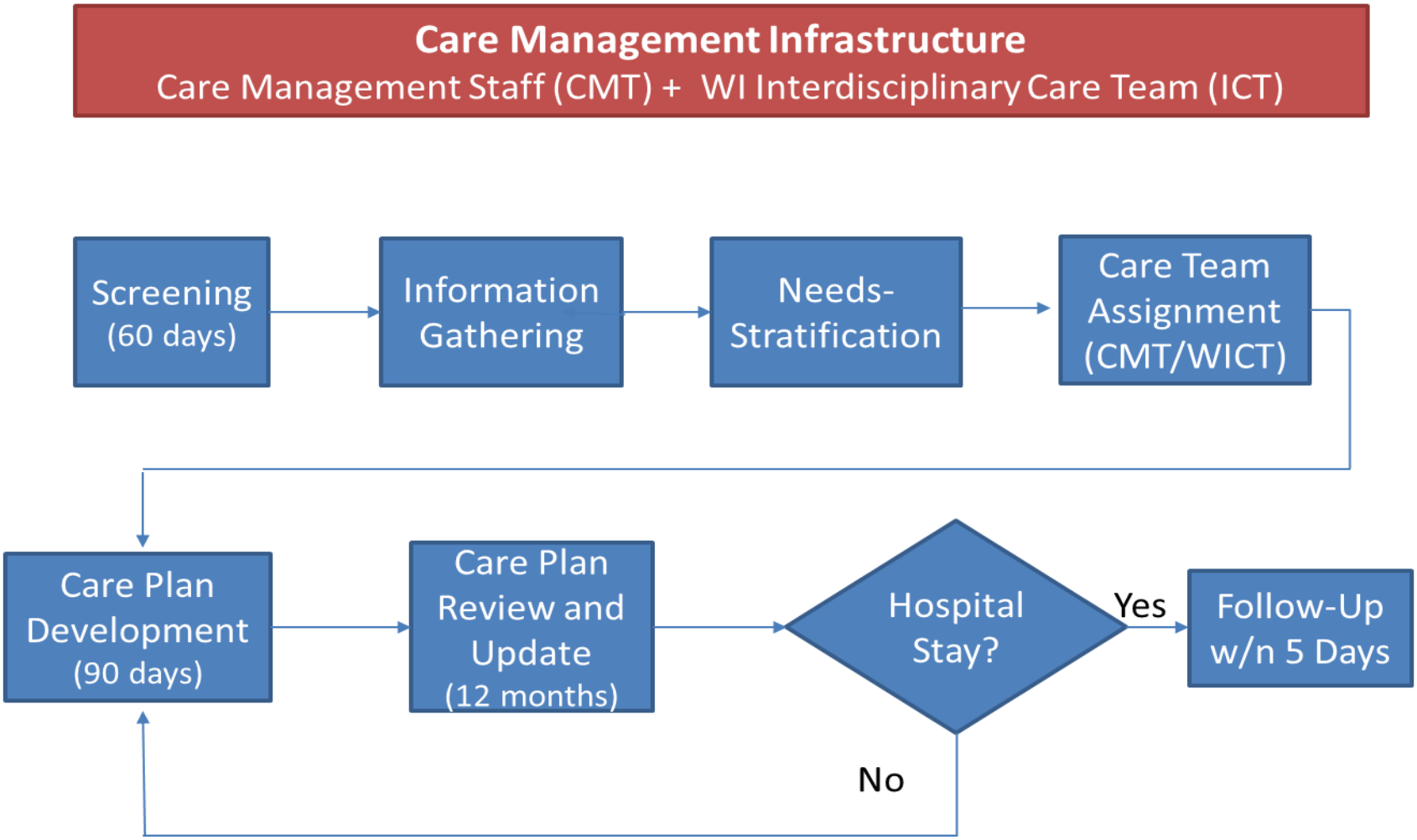
SSI Managed Care Background (continued)

- Initially
  - DHS pursued delivery system changes that would assign responsibility for complex members to either providers or health plans.
- After further consultations and looking at how the CCM model fits into the larger picture of health care quality in the State:
  - DHS has concluded that fundamentally, health plans and providers cannot assume responsibility and provide high quality care for complex members that move in and out of delivery systems.

SSI Managed Care Revised Strategy

- The Department adopted a revised strategy that allows for a staggered transformation of the delivery system that will support the Department's CCM goals.
  - Phase 1: Enhanced SSI Care Management Requirements (Implemented for January 1 2017)
  - Phase 2: Statewide SSI managed care expansion and enrollment policy alignment (Rollout begins January 2018)
  - Phase 3: Complex care management intervention pilot in Milwaukee County (Anticipated rollout Jan 2019)

SSI Managed Care
Phase 1: Care Management Infrastructure

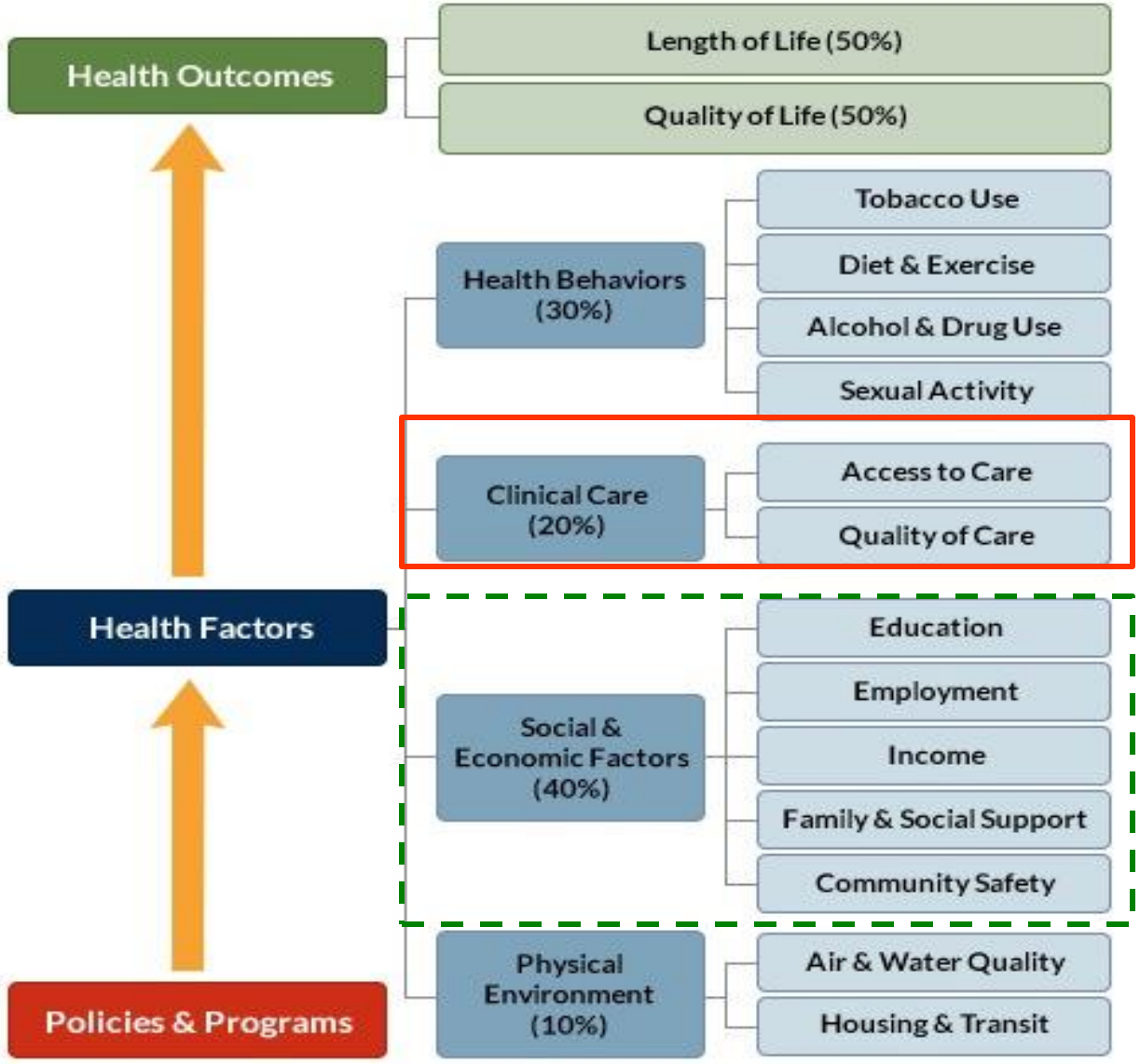


Wisconsin Department of Health Services

SSI Managed Care
Phase 1: Connect with Community-Based Model for Health Outcomes

Wisconsin Medica
care management
approach has
evolved:

- Initially focuse
on improving
access to care
and addressing
health needs.
- Now we are al
focused on
addressing
social
determinants
health.



SSI Managed Care
Phase 1: Wisconsin Interdisciplinary Care Team

To effectively manage the highest needs members, every HMO will have a Wisconsin Interdisciplinary Care Team (WICT):

- WICT is a group of health care professionals, including HMO partners, and other ancillary staff representing diverse disciplines who share a caseload and work together to share expertise, knowledge, and skills to help members meet their self-identified goals.
    - At a minimum, these teams should include two health care professionals with ready access to dedicated, internal resources with physical health, behavioral health, and social determinant expertise
- WICTs will be able to address needs beyond physical and behavioral health, including making sure their social determinants of health needs are addressed.
- Engagement of the WICT is intended to be a short-term intervention that moves the member to a higher level of self-management and then transitions the member to the HMO's standard care management model as the member's needs stabilizes.

SSI Managed Care
Phase 1: Care Management Model

- DHS introduced reimbursement changes to cover additional care management requirements outside of capitation payments.
- HMOs will submit specific codes through encounter data for activities such as:
  - Screening, care plan development and needs-stratification
  - Home visits
  - WICT meetings and conferences
  - Care plan review and updates
  - Follow-up after hospital discharge
- 2017 is a year for HMOs to develop the appropriate infrastructure and capabilities to support the care management model.
- DHS required SSI health plans to participate in WISHIN emergency department patient activity reports initiative

Wisconsin Department of Health Services

SSI Managed Care
Phase 2: Enrollment Alignment

- Phase 2: Align adult SSI managed care with BadgerCare Plus HMO enrollment policies, including the following specific changes.
  - Move away from a 60 day 'trial' period for SSI HMO enrollment with member ability to 'opt-out' of managed care.
  - Align with federal managed care rule and BadgerCare Plus enrollment policies to allow members to choose between multiple health plans and stay in selected plan for a 12 month lock-in period.
  - Align SSI choice period with BadgerCare choice period. SSI members currently receive 8-12 weeks to choose an HMO before being auto-enrolled into a plan. The Department recommends aligning choice period to same time frame as BadgerCare Plus, 4 weeks, which we believe is sufficient.

SSI Managed Care
Phase 2: Expansion

- Includes the current SSI fee-for-service members that opt-in/out.
  - No grandfathering provision is being considered.
  - Excludes children and SSI members enrolled in waiver programs or dual eligible.
- Expand adult SSI managed care enrollment statewide through a regional roll-out plan beginning 2018
  - Milwaukee timeline (estimated)
    - choice period begins March 2018
    - Auto-enrollment begins April/May 2018

SSI Managed Care
Phase 3: Complex Care Management Payment Model

- Concept
  - Target high needs (medical and social) and high cost members
  - Require managed care organizations to provide non fee-for-service value-based payment to community partners/providers
- Timeline
  - Develop during 2018
  - Implement with plans and providers 2019

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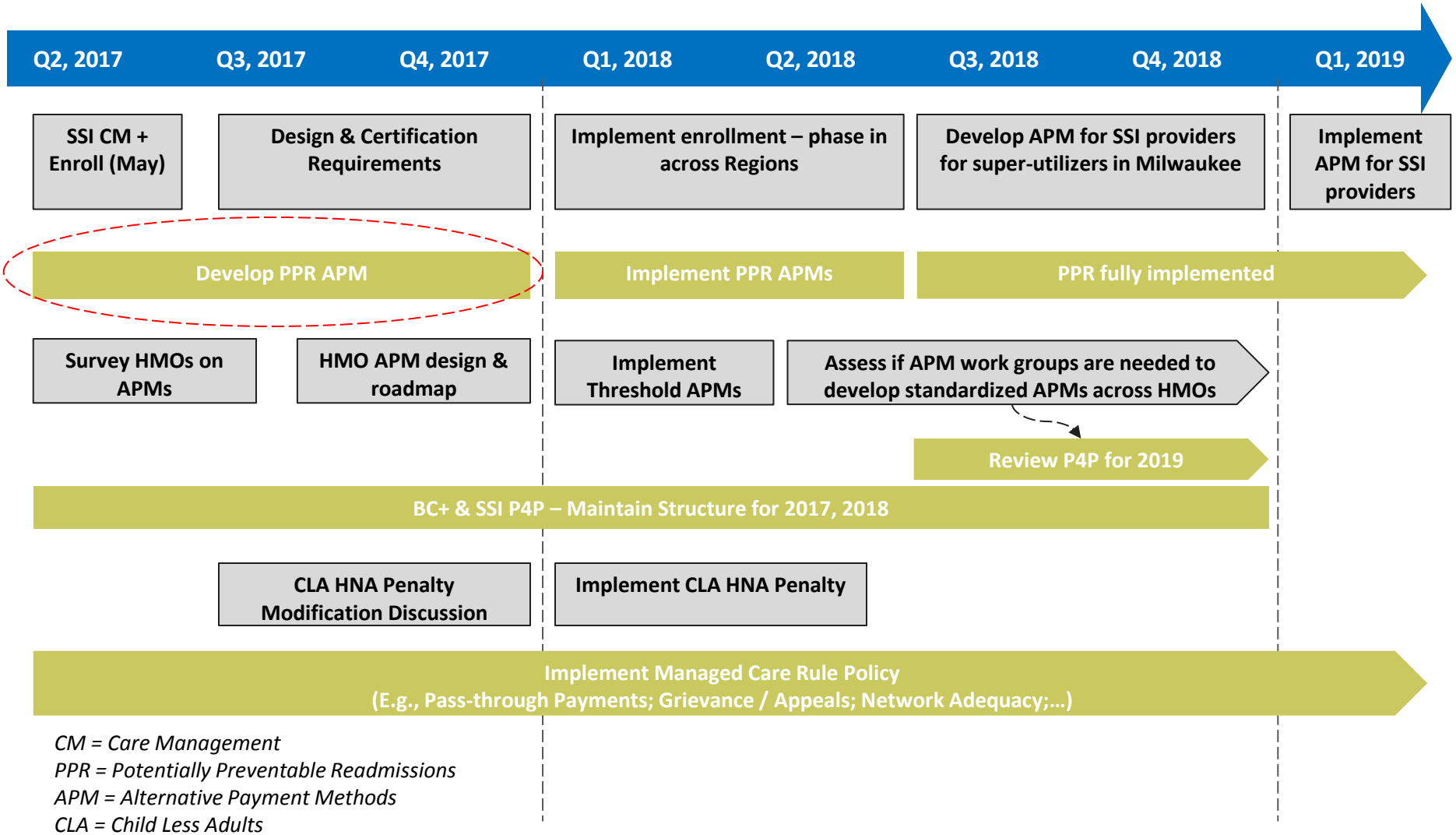
HMO Quality Roadmap



CM = Care Management
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CLA = Child Less Adults
HNA = Health Needs Assessment

Hospital P4P Evolution

- Introduced in 2012
  - Applies to all hospitals, except state mental health facilities
  - Funded through a 1.5 percent withhold of fee-for-service hospital claims, about $9 million
  - All money is returned to the hospitals
- Measures have evolved and include:
  - 30-day all-cause readmission
  - Follow-up after mental health hospitalization
  - Infections
  - Patient satisfaction
  - Perinatal care
  - Health care personnel flu vaccination
- Future
  - Focus on potentially preventable readmissions (PPR) in 2018

Potentially Preventable Readmissions (PPR) and Quality

- DHS is currently tracking PPRs using 3M software with the assistance of Navigant Consulting
- 3M PPRs are a way to identify hospital readmissions which should not have occurred with proper care
- Health plans will be accountable for reducing inappropriate hospital readmissions beginning January 1, 2018

PPR and Quality…continued

- DHS will establish a health plan specific target for a specified reduction in PPRs
- DHS will offer incentives to health plans who reduce their PPRs
- DHS will require incentive payments to be shared with providers under a non fee-for-service arrangement
- DHS will approve each health plan's proposal for sharing the incentive
- PPRs will be incorporated into actuarial calculations

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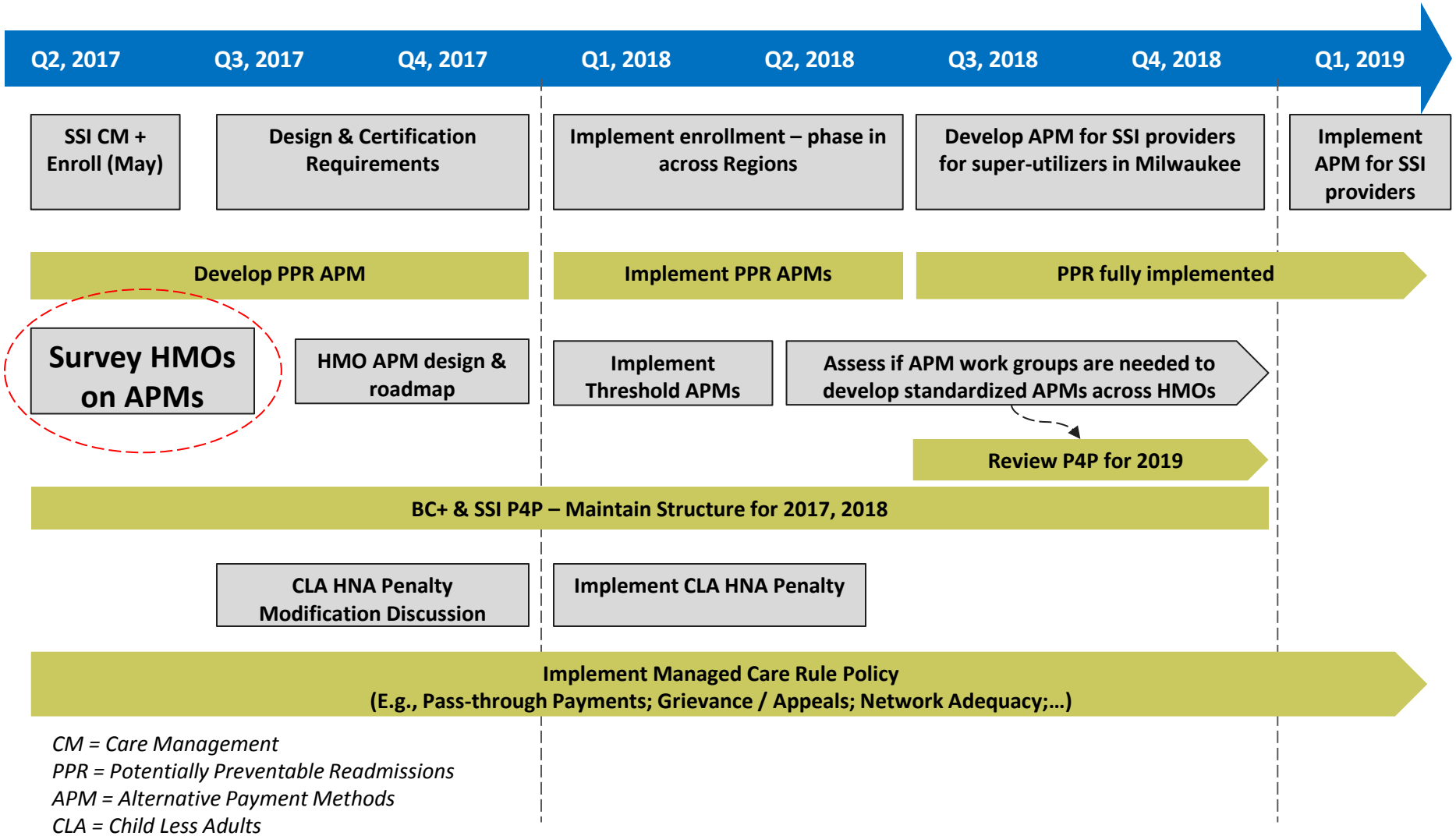
HMO Quality Roadmap (May 2017)



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APM Survey Template (Excerpt)

Medicaid APM Metrics

Look Back Metrics

Goal/Purpose – Establish a baseline for total dollars paid through legacy payments and alternative payment methods (APMs) in Calendar Year 2016 (January 1 – December 31). This report is based on **actual dollars** paid (incurred payment date, and NOT dates of service) to providers.

Methods

HMOs should report actual dollars paid to providers through APMs for the specified reporting time period. The definitions used for APM categories are consistent with the HCP LAN framework included in the APM reference material. The denominator

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers in FY 2016 or the applicable dates for the reporting period. (Not by dates of service.)

Instructions:

Fill in the cells that are shaded yellow in this worksheet and in the one labeled "Subcategories". Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions document provided as reference material.

A	B	C	D	E	F	G
#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Calculation
Alternative Payment Model Framework (Metrics below apply to **total** dollars paid for Medicaid beneficiaries. Metrics are NOT linked to quality)						
	NA	NA	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified time period (1/1/2016 – 12/31/2016)	$0.00	Denominator to inform the metrics below	NA
Alternative Payment Model Framework – Category 2 (All methods below ARE linked to quality during the reporting period).						
2A	Total dollars paid to providers for **foundational payments** to improve care (Category 2A) in the reporting period e.g. care coordination payments, HIT	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in the reporting period for this category.	$0.00	Payment Reform – APM dollars paid in Category 2A as percentage of overall total dollars paid to providers	#DIV/0!
2B	Total dollars paid to providers in **pay for reporting** APMs (Category 2B)	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in the reporting period for this category.	$0.00	Payment Reform – APM dollars paid in Category 2B as percentage of overall total dollars paid to providers	#DIV/0!
2C	Total dollars **paid to** providers in **pay for performance** APMs (Category 2C/2D – **bonus only**)	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in the reporting period for this category.	$0.00	Payment Reform – APM dollars paid in Category 2C/2D as percentage of overall total dollars paid to providers	#DIV/0!
2D	Total dollars **collected** from providers in **pay for performance** APMs (Category 2D – **penalties only**). Include this as a **positive** number.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in the reporting period for this category.	$0.00	Payment Reform – APM dollars paid in Category 2D as percentage of overall total dollars paid to providers	#DIV/0!

APM Terms & Definitions (Excerpt)

APM Terms and Definitions 6-20-2017.docx

APM Term	Definition
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value, including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the updated APM Framework White Paper (May 2017): http://hcp-lan.org/workproducts/apm-framework-refresh-draft.pdf
APM Payments	The dollars paid through various APMs (numerator) are **actual dollars** paid to providers during the Payment Reporting Period, and are **not** by date of service.
Attribution	A methodology that uses patient attestation and claims/encounter data to assign a patient population to a provider group/delivery system to manage the population's health, with calculated health care costs/savings or quality of care scores for that population. For some products, an individual consumer may select a network of physicians at the point of enrollment in a health plan (e.g. HMO). The Framework is agnostic to the attribution method (e.g. prospective or concurrent).
Category 1	Fee-for-service with **no link to quality**. These payments utilize traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.
Category 2 APM (must be linked to quality)	Fee-for-service **linked to quality**. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples include:

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HMO Report Card 2015 BC+

BadgerCare Plus HMO Ratings

BadgerCare Plus HMO	Staying Healthy	Living with Illness	Mental Health	Pregnancy & Birth	Emergency Department	Overall (out of 5)
Anthem Blue Cross Blue Shield	★★★★	★★★	★★★	★★★	★★	3.0
Childrens Community Health Plan	★★★★★	★★	★★★	★	★★★	2.9
CompCare	★★★★	★★★	★★★	★★★★	★★★★	3.3
Dean Health Plan	★★★★	★★★★★	★★★★	★★★★★	★★★★★	4.5
Group Health Cooperative - Eau Claire	★★★★★	★★★★	★★★★	★★★★★	★★★★★	4.1
Group Health Cooperative - South Central	★★★★★	★★★★★	★★★	★★★★★	★★★★★	4.0
Gundersen Health Plan	★★★★★	★★★★★	★★★★	★★★★★	★★★★★	4.7
Health Tradition Health Plan	★★★★★	★★★★★	★★★	★★★★★	★★★★★	4.3
Independent Care Health Plan (iCare)	★★★★★	★★★	★★★	★★	★	2.9
MercyCare Insurance Company	★★★★★	★★★★★	★★★	★★★★★	★★	3.9
MHS Health Wisconsin	★★★★★	★★★★	★★★	★★★★	★★	3.6
Molina Healthcare	★★★	★★★	★★	★	★★	2.2
Network Health Plan	★★★	★★★	★★★★	★★★★	★★★	3.6
PhysiciansPlus Insurance	★★★★★	★★★★★	★★★★	★★★★★	★★★★★	4.4
Security Health Plan	★★★★★	★★★★★	★★★★	★★★★★	★★★★★	4.6
Trilogy Health Insurance	Insufficient data	★	★★	★	★	1.5
United Health Care Community Plan	★★★★★	★★★★★	★★★★★	★★★★★	★★★	4.6
Unity Health Insurance	★★★★★	★★★★★	★★★	★★★★★	★★★★★	4.4
All Wisconsin Medicaid HMOs [1]	★★★★★	★★★★	★★★★	★★★★	★★★	3.8

1=Wisconsin state-wide average compared to national benchmark.

HMO Report Card 2015 BC+ - Dental

BadgerCare Plus HMO Ratings – Dental Care

Ratings are for HMOs providing dental care in south-eastern Wisconsin.

BadgerCare Plus HMO	Dental Care
Anthem Blue Cross Blue Shield	★★
Childrens Community Health Plan	★★★★
Independent Care Health Plan (iCare)	★★
MHS Health Wisconsin	★★
Molina Healthcare	★★
Network Health Plan	★★
Trilogy Health Insurance	★
United Health Care Community Plan	★★
All Wisconsin Medicaid HMOs [1]	★★

1 = Wisconsin average compared to national benchmark for dental care for children.

HMO Report Card 2015 SSI

Medicaid SSI HMO Ratings

No national comparisons are available for Medicaid SSI HMOs;

HMOs earned stars based on their performance compared to Wisconsin state-wide averages.

Medicaid SSI HMO	Staying Healthy	Living with Illness	Mental Health	Emergency Department	Overall (out of 5)
Anthem	Began serving Medicaid SSI members in 2015; Not enough data for 2015				
CareWisconsin	Insufficient data	★★★	★★★	★★★	2.8
CompCare	Insufficient data	★★★	★★★★★	★★★	3.7
Group Health Cooperative - Eau Claire	★★★★	★★★★	★★★	★★★★★	3.4
Independent Care Health Plan (iCare)	★★★	★★★	★★★★	★★★	3.3
MHS Health Wisconsin	★★★	★★★	★★	★★★★	2.8
Molina Healthcare	★★★★	★★★	★★	★★★	2.6
Network Health Plan	★★	★★★★	★★★	★★★★	3.2
United Health Care Community Plan	★★★★	★★★★	★★★★★	★★★	4.0

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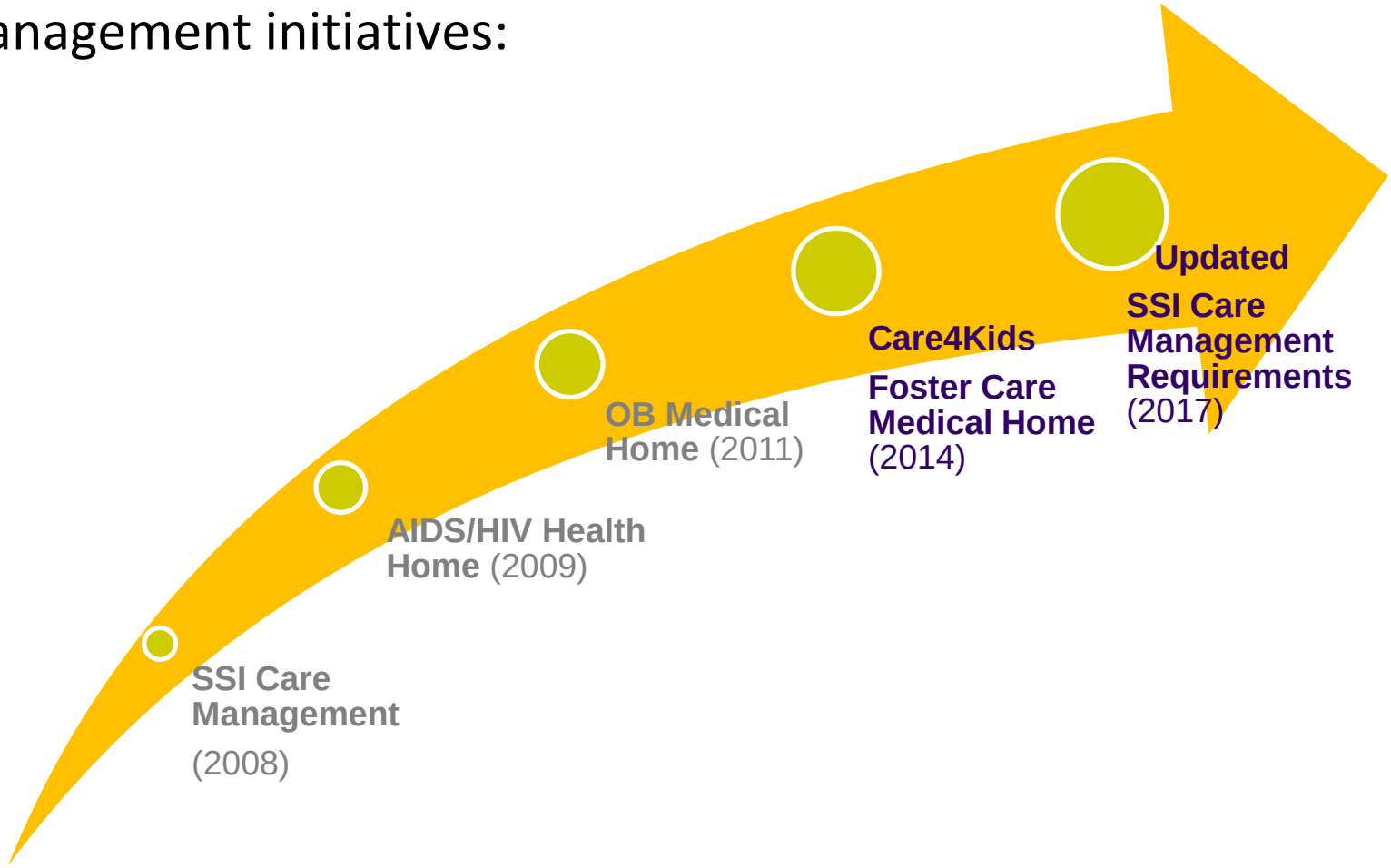
Care Management Approach in Wisconsin Medicaid

Wisconsin Medicaid has extensive experience implementing care management initiatives:



Conclusion

- Medicaid HMO Quality and Value Road Map incorporates strategies developed in partnership with stakeholders from 2015 State Health Improvement Plan

- Provides opportunities for collaboration across plans and health systems in geographic regions
  - Potentially Preventable Readmissions Incentive Payment
  - Complex Case Management – Alternate Payment Models
  - Alternate Payment Models Survey and Threshold Development